FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039826

Facility Name: Mount Vernon Care Center

Address: 1717 Jefferson Street (Number) Mount Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: (618) 244-2861 **Fax #** (618) 244-7677

IDPA ID Number: 391516877002

Date of Initial License for Current Owners: 10/01/94

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan **Telephone Number:** (312) 207-2264
Altschuler, Melvoin & Glasser LLP
30 South Wacker Drive
Chicago, IL 60606-7494
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/99 to 6/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, 30 South Wacker Drive, Chicago, Il 60606-7494
(Telephone) (312) 207-2264 Fax # (312) 207-2958

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	64	Intermediate (ICF)	64	23,424	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	64	TOTALS	64	23,424	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	17,223	4,154		21,377	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,223	4,154		21,377	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.26%

D. How many bed-hold days during this year were paid by Public Aid? 96 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 10/1/94

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 10/1/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified N/A and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 6/30/00 Fiscal Year: 6/30/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7 **	8	9	10	
1	Dietary	75,116	6,434	3,921	85,471		85,471		85,471			1
2	Food Purchase		83,869		83,869		83,869	(11,715)	72,154			2
3	Housekeeping	57,277	4,784		62,061		62,061		62,061			3
4	Laundry	34,948	8,226		43,174		43,174		43,174			4
5	Heat and Other Utilities			37,189	37,189		37,189	172	37,361			5
6	Maintenance	25,449		22,691	48,140		48,140	2,908	51,048			6
7	Other (specify):*											7
8	**TOTAL General Services**	192,790	103,313	63,801	359,904		359,904	(8,635)	351,269			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	489,270	17,507	514	507,291		507,291		507,291			10
10a	Therapy			1,927	1,927		1,927		1,927			10a
11	Activities	24,521	3,408	2,191	30,120		30,120	284	30,404			11
12	Social Services	15,847	163	1,501	17,511		17,511		17,511			12
13	Nurse Aide Training											13
14	Program Transportation			826	826		826		826			14
15	Other (specify):* Routine Dental			62	62		62		62			15
16	**TOTAL Health Care and Programs**	529,638	21,078	13,021	563,737		563,737	284	564,021			16
	C. General Administration											
17	Administrative	58,969		60,088	119,057		119,057	(60,088)	58,969			17
18	Directors Fees			(77)	(77)		(77)	8,760	8,683			18
19	Professional Services			13,961	13,961		13,961	34,335	48,296			19
20	Dues, Fees, Subscriptions & Promotions			4,179	4,179		4,179	1,688	5,867			20
21	Clerical & General Office Expenses	93,763	7,469	14,598	115,830		115,830	26,460	142,290			21
22	Employee Benefits & Payroll Taxes			94,727	94,727		94,727	96,977	191,704			22
23	Inservice Training & Education			60	60		60	3,216	3,276			23
24	Travel and Seminar			4,073	4,073		4,073	6,749	10,822			24
25	Other Admin. Staff Transportation			592	592		592	458	1,050			25
26	Insurance-Prop.Liab.Malpractice			100	100		100	22,257	22,357			26
27	Other (specify):*											27
28	**TOTAL General Administration**	152,732	7,469	192,301	352,502		352,502	140,812	493,314			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	875,160	131,860	269,123	1,276,143		1,276,143	132,461	1,408,604			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Mount Vernon Care Center #0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			5,768	5,768		5,768	68,491	74,259			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,199	5,199		5,199	174,998	180,197			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			212,426	212,426		212,426	(206,884)	5,542			34
35	Rent-Equipment & Vehicles			4,995	4,995		4,995	6,023	11,018			35
36	Other (specify):* **Insurance-MIP**							9,905	9,905			36
37	**TOTAL Ownership**			228,388	228,388		228,388	52,533	280,921			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			48	48		48	1,152	1,200			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,136	35,136		35,136		35,136			42
43	Other (specify):* **Nonallowable costs**			5,247	5,247		5,247	(5,247)				43
44	**TOTAL Special Cost Centers**			40,431	40,431		40,431	(4,095)	36,336			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	875,160	131,860	537,942	1,544,962		1,544,962	180,899	1,725,861			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(305)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,272	30		9
10	Interest and Other Investment Income	(7,212)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(4,243)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(200)	43		18
19	Entertainment				19
20	Contributions	(27)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,394)	43		24
25	Fund Raising, Advertising and Promotional	(1,496)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(825)	43		28
29	Other-Attach Schedule See attached Schedule 5A	5,825			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (6,605)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	187,504		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 187,504		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 180,899		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Mount Vernon Care Center
Provider #0039826
June 30, 2000

Schedule VI. Part A - Adjustment Detail, Line 29

Non-allowable expenses	Amount	Reference
Miscellaneous income offset	(406)	21
Interest Income	6,202	n/a
Miscellaneous income offset	29	n/a
Total	5,825	

STATE OF ILLINOIS **Page 5A**

Mount Vernon Care Center

ID# 0039826

Report Period Beginning: 7/1/99

Ending: 6/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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41				41
42				42
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75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Caravilla Resident Centers, Inc. - See attached Schedule 7A	100.00%	See attached Related Party Schedule		See attached Related Party Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Repairs & maintenance	$	Center for Residential Management, Inc.	**	$ 736	$ 736	1
2	V	10	Medical supplies		Center for Residential Management, Inc.	**			2
3	V	11	Activity programming		Center for Residential Management, Inc.	**			3
4	V	17	Management fees	31,622	Center for Residential Management, Inc.	**	31,677	55	4
5	V	18	Board fees		Center for Residential Management, Inc.	**	3,018	3,018	5
6	V	19	Professional fees		Center for Residential Management, Inc.	**	5,376	5,376	6
7	V	20	Licenses, dues & subscriptions		Center for Residential Management, Inc.	**	815	815	7
8	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	7,656	7,656	8
9	V	22	Employee benefits & payroll taxes		Center for Residential Management, Inc.	**	22,596	22,596	9
10	V	23	Inservice travel & education		Center for Residential Management, Inc.	**	21	21	10
11	V	24	Travel & seminar		Center for Residential Management, Inc.	**	2,374	2,374	11
12	V	25	Vehicle expense		Center for Residential Management, Inc.	**	362	362	12
13	V	26	Vehicle, fire & liability insurance		Center for Residential Management, Inc.	**	228	228	13
14	Total			$ 31,622			$ 74,859	$ * 43,237	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

** Center for Residential Management, Inc. is Caravilla Resident Centers, Inc.'s parent company.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Center for Residential Management, Inc.	**	$ 1,260	$ 1,260	15
16	V	32	Interest expense		Center for Residential Management, Inc.	**	822	822	16
17	V	39	Ancillary service centers		Center for Residential Management, Inc.	**	1,152	1,152	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 3,234	$ * 3,234	39

** Center for Residential Management, Inc. is Caravilla Resident Centers, Inc.'s parent company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management fees	$	Caravilla Resident Centers, Inc.	100.00%	$ 10,750	$ 10,750	15
16	V	18	Board fees		Caravilla Resident Centers, Inc.	100.00%	5,742	5,742	16
17	V	19	Professional fees		Caravilla Resident Centers, Inc.	100.00%	3,730	3,730	17
18	V	20	Licenses, dues & subscriptions		Caravilla Resident Centers, Inc.	100.00%	243	243	18
19	V	21	Office supplies & telephone		Caravilla Resident Centers, Inc.	100.00%	674	674	19
20	V	22	Employee benefits & payroll taxes		Caravilla Resident Centers, Inc.	100.00%	53,282	53,282	20
21	V	24	Travel & seminar		Caravilla Resident Centers, Inc.	100.00%	26	26	21
22	V	26	Vehicle, fire & liability insurance		Caravilla Resident Centers, Inc.	100.00%	5,944	5,944	22
23	V	32	Interest expense		Caravilla Resident Centers, Inc.	100.00%	2,314	2,314	23
24	V	36	Insurance - MIP		Caravilla Resident Centers, Inc.	100.00%	9,905	9,905	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 92,610	$ * 92,610	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Developmental Services of Illinois, Inc.	**	$ 172	$ 172	15
16	V	6	Repairs & maintenance		Developmental Services of Illinois, Inc.	**	2,172	2,172	16
17	V	11	Activity programming		Developmental Services of Illinois, Inc.	**	284	284	17
18	V	17	Management fees	70,893	Developmental Services of Illinois, Inc.	**		(70,893)	18
19	V	19	Professional fees		Developmental Services of Illinois, Inc.	**	20,916	20,916	19
20	V	20	Licenses, dues & subscriptions		Developmental Services of Illinois, Inc.	**	626	626	20
21	V	21	Office supplies & telephone		Developmental Services of Illinois, Inc.	**	18,402	18,402	21
22	V	22	Employee benefits & payroll taxes		Developmental Services of Illinois, Inc.	**	9,384	9,384	22
23	V	23	Inservice travel & education		Developmental Services of Illinois, Inc.	**	3,195	3,195	23
24	V	24	Travel & seminar		Developmental Services of Illinois, Inc.	**	4,349	4,349	24
25	V	25	Vehicle expense		Developmental Services of Illinois, Inc.	**	96	96	25
26	V	26	Vehicle, fire & liability insurance		Developmental Services of Illinois, Inc.	**	1,476	1,476	26
27	V	30	Depreciation		Developmental Services of Illinois, Inc.	**	1,702	1,702	27
28	V	32	Interest expense		Developmental Services of Illinois, Inc.	**	10,043	10,043	28
29	V	34	Rent		Developmental Services of Illinois, Inc.	**	5,542	5,542	29
30	V	35	Vehicle lease & equipment rental		Developmental Services of Illinois, Inc.	**	6,023	6,023	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 70,893			$ 84,382	$ * 13,489	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

** Developmental Services of Illinois, Inc. is Caravilla Resident Centers, Inc.'s management company.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Caravilla Charitable Corporation	**	$ 4,313	$ 4,313	15
16	V	20	Licenses, dues & subscriptions		Caravilla Charitable Corporation	**	4	4	16
17	V	21	Office supplies & telephone		Caravilla Charitable Corporation	**	134	134	17
18	V	26	Vehicle, fire & liability insurance		Caravilla Charitable Corporation	**	14,609	14,609	18
19	V	30	Depreciation		Caravilla Charitable Corporation	**	61,257	61,257	19
20	V	32	Interest expense		Caravilla Charitable Corporation	**	173,274	173,274	20
21	V	34	Rent expense	212,426	Caravilla Charitable Corporation	**		(212,426)	21
22	V	n/a	Interest income		Caravilla Charitable Corporation	**	(6,202)	(6,202)	22
23	V	n/a	Miscellaneous income		Caravilla Charitable Corporation	**	(29)	(29)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 212,426			$ 247,360	$ * 34,934	39

** Caravilla Charitable Corporation and Caravilla Resident Centers, Inc. have the same parent company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Robert Bauer	President	Board Member	None	10,456	2 hrs/mtg.		Directors Fees	$ 1,544	L18, C8	1
2	Duane Satterwhite	Director	Board Member	None	2,328	2 hrs/mtg.		Directors Fees	872	L18, C8	2
3	Roger Ryan	Vice President	Board Member	None	2,329	2 hrs/mtg.		Directors Fees	871	L18, C8	3
4	Ronald O'Daniell	Director	Board Member	None	2,329	2 hrs/mtg.		Directors Fees	871	L18, C8	4
5	William Armstrong	Treasurer	Board Member	None	2,328	2 hrs/mtg.		Directors Fees	872	L18, C8	5
6	Darrell Boehne	Director	Board Member	None	12,328	2 hrs/mtg.		Directors Fees	672	L18, C8	6
7	Kay Baker	Secretary	Board Member	None	2,329	2 hrs/mtg.		Directors Fees	871	L18, C8	7
8	Ronald Schroeder	Director	Board Member	None	13,346	2 hrs/mtg.		Directors Fees	454	L18, C8	8
9	Edward Childers	Director	Board Member	None	13,433	2 hrs/mtg.		Directors Fees	567	L18, C8	9
10	Eugene Humphrey	Director	Board Member	None	7,546	2 hrs/mtg.		Directors Fees	454	L18, C8	10
11	Orland Bauer	Director	Board Member	None	8,347	2 hrs/mtg.		Directors Fees	453	L18, C8	11
12	Shawn Jeffers	Director	Board Member	None	3,018	2 hrs/mtg.		Directors Fees	182	L18, C8	12
13								TOTAL	$ 8,683		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.
SEE ATTACHED SCHEDULE 7A

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Center for Residential Management, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	6	Repairs & maintenance	Bed days available	206,424	20	6,488		23,424	736	2
3	17	Management fees	Bed days available	206,424	20	279,150		23,424	31,677	3
4	18	Board fees	Bed days available	206,424	20	26,600		23,424	3,018	4
5	19	Professional fees	Bed days available	206,424	20	47,365		23,424	5,376	5
6	20	Licenses, dues & subscriptions	Bed days available	206,424	20	401		23,424	45	6
7	21	Office supplies & telephone	Bed days available	206,424	20	14,574		23,424	1,650	7
8	22	Employee benefits & payroll taxes	Bed days available	206,424	20	27,615		23,424	3,135	8
9	24	Travel & seminar	Bed days available	206,424	20	7,941		23,424	901	9
10	25	Vehicle expense	Bed days available	206,424	20	3,189		23,424	362	10
11	26	Vehicle, fire & liability insurance	Bed days available	206,424	20	2,009		23,424	228	11
12	30	Depreciation	Bed days available	206,424	20	11,103		23,424	1,260	12
13	32	Interest expense	Bed days available	206,424	20	7,240		23,424	822	13
14										14
15										15
16										16
17										17
18	20	Licenses, dues & subscriptions	Direct method						770	18
19	21	Office supplies & telephone	Direct method						6,006	19
20	22	Employee benefits & payroll taxes	Direct method						19,461	20
21	23	Inservice travel & education	Direct method						21	21
22	24	Travel & seminar	Direct method						1,473	22
23	39	Ancillary service centers	Direct method						1,152	23
24										24
25	TOTALS					$ 433,675	$		$ 78,093	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Caravilla Resident Centers, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management fees	Number of beds	235	3	$ 34,250	$	64	$ 10,750	1
2	18	Board fees	Number of beds	235	3	20,800		64	5,742	2
3	19	Professional fees	Number of beds	235	3	13,817		64	3,730	3
4	20	Licenses, dues & subscriptions	Number of beds	235	3	892		64	243	4
5	21	Office supplies & telephone	Number of beds	235	3	2,468		64	674	5
6	24	Travel & seminar	Number of beds	235	3	380		64	26	6
7	32	Interest expense	Number of beds	235	3	8,499		64	2,314	7
8										8
9	22	Employee benefits & payroll taxes	Direct method						53,282	9
10	26	Vehicle, fire & liability insurance	Direct method						5,944	10
11	36	Insurance - MIP	Direct method						9,905	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 81,106	$		$ 92,610	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Developmental Services of Illinois, Inc.
Street Address: 4239 W. War Memorial Drive, Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed days available	206,424	20	$ 1,518	$	23,424	$ 172	1
2	6	Repairs & maintenance	Bed days available	206,424	20	19,133		23,424	2,172	2
3	11	Activity programming	Bed days available	206,424	20	2,500		23,424	284	3
4	19	Professional fees	Bed days available	206,424	20	184,323		23,424	20,916	4
5	20	Licenses, dues & subscriptions	Bed days available	206,424	20	5,518		23,424	626	5
6	21	Office supplies & telephone	Bed days available	206,424	20	162,176		23,424	18,402	6
7	22	Employee benefits & payroll taxes	Bed days available	206,424	20	82,697		23,424	9,384	7
8	23	Inservice travel & education	Bed days available	206,424	20	28,154		23,424	3,195	8
9	24	Travel & seminar	Bed days available	206,424	20	38,328		23,424	4,349	9
10	25	Vehicle expense	Bed days available	206,424	20	846		23,424	96	10
11	26	Vehicle, fire & liability insurance	Bed days available	206,424	20	13,012		23,424	1,476	11
12	30	Depreciation	Bed days available	206,424	20	15,000		23,424	1,702	12
13	32	Interest expense	Bed days available	206,424	20	88,507		23,424	10,043	13
14	34	Rent	Bed days available	206,424	20	48,842		23,424	5,542	14
15	35	Vehicle lease & equipment rental	Bed days available	206,424	20	53,081		23,424	6,023	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 743,635	$		$ 84,382	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Continental Wingate		x	Purchase facility	$55,560.00	9/1/96	$ 7,402,500	$ 1,975,473	10/01/31	0.0855	$ 169,471	1
2	NCS Healthcare, Inc.		x	Hardware/Software	$689.00	10/31/98	27,579	17,352	09/30/03	0.1429	1,548	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$56,249.00		$ 7,430,079	$ 1,992,825			$ 171,019	9
	B. Non-Facility Related*											
10							Miscellaneous interest				4,243	10
11							Nonallowable interest expense and interest income offset				(11,320)	11
12							Amortization expense				5,525	12
13							Parent and management company allocation				10,730	13
14	TOTAL Non-Facility Related						$	$			$ 9,178	14
15	TOTALS (line 9+line14)						$ 7,430,079	$ 1,992,825			$ 180,197	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center **#** 0039826 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	N/A $	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,500 B. General Construction Type: Exterior Brick Frame Block Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	81,300	1994	60,000	1
2					2
3	TOTALS	81,300		$ 60,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1994	1994	$ 1,229,600	$	40	$ 30,740	$ 30,740	$ 176,755	4
5			1998	1998	5,394		40	135	135	337	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvements			1995	3,187		15	212	212	1,127	9
10	Architectural services			1996	4,794		15	320	320	1,080	10
11	Architectural services			1997	1,198		15	80	80	270	11
12	Air compressor			1996	1,230		15	82	82	277	12
13	Electrical			1996	1,710		15	114	114	385	13
14	Exit lighting			1997	1,354		15	90	90	304	14
15	Blinds, wallpaper & paint			1997	3,329		15	222	222	745	15
16	Waterproof basement			1997	7,822		15	521	521	1,759	16
17	Windows & doors			1997	2,878		15	192	192	648	17
18	Plastering			1997	20,386		15	1,359	1,359	4,587	18
19	Flooring			1997	4,544		15	303	303	757	19
20	Gutters			1997	8,933		15	596	596	1,490	20
21	Shutters & windows			1997	1,882		15	125	125	313	21
22	Remodeling of facility			1997	4,153		15	277	277	692	22
23	Plumbing			1997	15,420		15	1,028	1,028	2,570	23
24	Electrical service			1997	32,765		15	2,184	2,184	5,460	24
25	Paint & wallpaper			1997	8,366		15	558	558	1,395	25
26	Sidewalk			1997	780		15	52	52	130	26
27	Electrical service			1998	1,340		15	89	89	223	27
28	Flooring			1998	27,771		15	1,851	1,851	4,628	28
29	Remodeling of facility			1998	154		15	10	10	25	29
30	Paint & wallpaper			1998	262		15	17	17	43	30
31	Landscaping			1998	7,964		15	531	531	1,327	31
32	Windows			1998	1,599		15	107	107	267	32
33	Air conditioner			1998	578		15	39	39	98	33
34	Landscaping			1999	1,699		15	113	113	170	34
35	Cabinets			1999	1,220		15	81	81	122	35
36	TOTAL (lines 4 thru 35)				$ 1,402,312	$		$ 42,028	$ 42,028	$ 207,984	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4								$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Renovation of nurse station			1999	6,059		15	404	404	606	9
10	Security system			1999	1,245		15	83	83	125	10
11	Water heater			1999	1,990	66	15	66		66	11
12	Remodel resident rooms			1999	3,343		15	111	111	111	12
13	Remodel resident rooms			1999	3,477		15	116	116	116	13
14	Remodel common room			1999	942		15	31	31	31	14
15	Remodel common room			1999	3,212		15	107	107	107	15
16	Trim			1999	671		15	22	22	22	16
17	Door			2000	984	33	15	33		33	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 21,923	$ 99		$ 973	$ 874	$ 1,217	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 202,023	$ 3,472	$ 22,746	$ 19,274	5 - 10 yrs	$ 98,812	37
38	Current Year Purchases	21,218	425	1,061	636	5 - 10 yrs	1,061	38
39	Fully Depreciated Assets							39
40	Parent and management company allocation			2,962	2,962			40
41	TOTALS	$ 223,241	$ 3,897	$ 26,769	$ 22,872		$ 99,873	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Transportation	1997 Ford E150*	1997	13,040		2,717	$ 2,717	3	13,040	42
43	Resident Transportation	1997 GMC Van*	1999	5,315	1,772	1,772		3	2,658	43
44										44
45		* Cost allocated between 3 facilities								45
46	TOTALS			$ 18,355	$ 1,772	$ 4,489	$ 2,717		$ 15,698	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,725,831	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 5,768	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 74,259	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 68,491	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 324,772	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Parent and management company allocation				5,542			6
7	TOTAL				$ 5,542 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [x] YES [ ] NO

16. Rental Amount for movable equipment: $ 8,099 Description: Dishwasher $1590; Trailer $366; Water cooler $96; Misc. equipment $34; Mgmt. Co. allocation $6,013
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Care	1996 Chevy Lumina	$ 136.00	$ 1,634	17
18	Resident Care	1991 Ford Taurus Wagon	10.00	1,275	18
19					19
20	Management company allocation			10	20
21	TOTAL		$ 146.00	$ 2,919	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$			$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Part B MCR Supplies	L39, C8					1,152		1,152	13
	Emergency Dental	L39, C3			1	48		1	48	
14	TOTAL			$	1	$ 48	$ 1,152	1	$ 1,200	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 74	$ 74	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	70,042	70,042	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17	17	6
7	Other Prepaid Expenses	7,690	7,690	7
8	Accounts Receivable (owners or related parties)	442,874	442,874	8
9	Other(specify): Deposit	545	545	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 521,242	$ 521,242	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		60,000	13
14	Buildings, at Historical Cost		1,234,994	14
15	Leasehold Improvements, at Historical Cost	2,973	189,241	15
16	Equipment, at Historical Cost	32,323	241,596	16
17	Accumulated Depreciation (book methods)	(9,146)	(324,772)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,521	2,521	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Investment in Sub.	1,500	1,500	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 30,171	$ 1,405,080	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 551,413	$ 1,926,322	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 60,747	$ 60,747	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	49,853	49,853	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	63,486	63,486	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 174,086	$ 174,086	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	17,352	1,992,825	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 17,352	$ 1,992,825	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 191,438	$ 2,166,911	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 359,975	$ (240,589)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 551,413	$ 1,926,322	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Mount Vernon Care Center
Provider #0039826
June 30, 2000

XV. Balance Sheet

	Operating	After Consolidation
Line 36 - Other		
Accrued Expense	1,353	1,353
Accrued Legal and Accounting	3,865	3,865
Accrued Rent	26,553	26,553
Accrued Participation Fees	8,736	8,736
Resident Credit Balances	4,217	4,217
Accrued Respro	18,762	18,762
	63,486	63,486

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 482,436	1
2	Restatements (describe):		2
3	Prior year audit adjustment	(16,787)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 465,649	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,182)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Parent & management company allocation	(104,492)	15
16	Other (describe) added back in column 7		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (105,674)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 359,975	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,538,330	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,538,330	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	940	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 940	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	710	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,568	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,278	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,010	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,010	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	845	28
28a	Miscellaneous Income	377	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,222	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,543,780	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	359,904	31
32	Health Care	563,737	32
33	General Administration	352,502	33
	B. Capital Expense		
34	Ownership	228,388	34
	C. Ancillary Expense		
35	Special Cost Centers	5,295	35
36	Provider Participation Fee	35,136	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,544,962	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,182)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,182)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. A federal tax return is filed for the combined divisions of Caravilla Resident Centers, Inc.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Schedule XVII - Line 28 Other Revenue

Pinecrest Village Management Fee	
Pinecrest Village Meals	
Pinecrest Village Transportation	
Maintenance Services	
Service Supplies	
Vending Machine Income	
Miscellaneous Income	
Alzheimer's Unit Income	
Gain on disposal of fixed assets	
Total Line 28	0

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,896	2,008	29,546	$ 14.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	591	601	7,353	12.23	3
4	Licensed Practical Nurses	10,859	11,629	120,491	10.36	4
5	Nurse Aides & Orderlies	37,011	39,659	281,372	7.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,836	1,972	14,301	7.25	8
9	Activity Director					9
10	Activity Assistants	3,612	3,782	24,521	6.48	10
11	Social Service Workers	1,952	2,056	15,847	7.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,673	12,442	75,116	6.04	15
16	Dishwashers					16
17	Maintenance Workers	1,952	2,173	25,449	11.71	17
18	Housekeepers	8,914	9,474	57,277	6.05	18
19	Laundry	5,242	5,642	34,948	6.19	19
20	Administrator	1,800	1,976	34,052	17.23	20
21	Assistant Administrator					21
22	Other Administrative	1,040	1,075	24,917	23.18	22
23	Office Manager					23
24	Clerical	4,770	4,919	93,763	19.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	784	855	5,218	6.10	31
32	Other Health Care-See Sch 20A	2,840	3,023	30,989	10.25	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,772	103,286	$ 875,160 *	$ 8.47	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	84	$ 3,921	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	350	L10, C3	38
39	Pharmacist Consultant	Monthly	164	L10, C3	39
40	Physical Therapy Consultant	16	496	L10a, C3	40
41	Occupational Therapy Consultant	24	1,162	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	269	L10a, C3	43
44	Activity Consultant	43	1,909	L11,C3	44
45	Social Service Consultant	34	1,501	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	203	$ 15,772		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses				50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Mount Vernon Care Center
Provider #0039826
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XVII. A. Staffing and Salary Costs
Line 32 - Other Health Care

Title	Hours Worked	Hours Paid	Salaries	Average Hourly Wage
Care Plan Coordinator	2,056	2,176	25,816	11.86
Ancillary Clerk	784	847	5,173	6.11
Total	2,840	3,023	30,989	10.25

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carrell Breeze	Administrator	0.00%	$ 34,052
Parent company allocation	See attached Schedule 21 A		24,917
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,969

B. Administrative - Other

Description	Amount
Developmental Services of Illinois, Inc. - Management Fees	$ 28,466
Center for Residential Management, Inc. - Management Fees	31,622
(Management Fees are eliminated in column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 60,088
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consulting	$ 830
Altschuler, Melvoin & Glasser LLP	Accounting	11,360
Amer. Exp. Tax & Bus. Services	Accounting	1,771
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 13,961

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,318
Unemployment Compensation Insurance	13,796
FICA Taxes	64,219
Employee Health Insurance	45,482
Employee Meals	11,715
Illinois Municipal Retirement Fund (IMRF)*	
Hepatitis B Shots	596
Employee Morale	4,578
TOTAL (agree to Schedule V, line 22, col.8)	$ 191,704

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	763
Health Care Worker Background Check	
(Indicate # of checks performed 110)	773
IHCA Dues	2,582
MES Dues	175
Jefferson County Chamber of Commerce	276
Miscellaneous Dues and Licenses	558
Management company allocation	540
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,867

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,723
Seminar Expense	3,849
Parent company allocation	901
Management company allocation	4,349
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,822

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Mount Vernon Care Center
Provider #0039826
June 30, 2000

XIX. Support Schedules
Section C. Professional Services, Page 21

Total (agrees to Schedule V, line 19 column 3)		13,961
Caravilla Charitable Corporation:		
Altschuler, Melvoin & Glasser LLP	Accounting	3,650
American Express Tax & Business Services	Accounting	446
Mangum, Smietanka & Johnson	Legal	218
Parent company allocation:		
American Express Tax & Business Services	Accounting	307
Altschuler, Melvoin & Glasser LLP	Accounting	1,864
Mangum, Smietanka & Johnson	Legal	3,204
Management company allocation:		
American Express Tax & Business Services	Accounting	3,187
Altschuler, Melvoin & Glasser LLP	Accounting	6,049
ADP	Payroll Processing	10,358
Health Outcomes	Consulting	1,322
Corporate allocation:		
Altschuler, Melvoin & Glasser LLP	Accounting	2,300
American Express Tax & Business Services	Accounting	501
Mangum, Smietanka & Johnson	Legal	929
Total (agrees to Schedule V, line 19 column 8)		48,296

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8							N/A						
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 7/1/99 Ending: 6/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $2,582**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **379** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
n/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **35,136**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,715** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **44%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin and Glasser LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit is currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.